



BabyNet

South Carolina's Early Intervention System

SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

_____'s
Individualized Family Service Plan (IFSP)

Date of Referral: _____ Date of Plan: _____

SECTION 1: CHILD INFORMATION

Child's Name: _____ Date of Birth: _____

First Middle Last

Home Address: _____

City: _____ State: SC Zip Code: _____

Gender: ☐ M ☐ F Name of School District and/or Head Start _____

Social Security # _____ Medicaid #: _____

Private Insurance Company Name and Policy # _____

SECTION 2: GENERAL CONTACT INFORMATION

Parent/Guardian: _____ Relationship to Child: _____

First Last

Home Address: _____

Directions to the home: _____

Phone: Home _____ Work: _____ Other: _____

E-mail: _____

Primary Language/Mode of Communication: _____ Interpreter Needed: ☐ Y ☐ N

Surrogate Parent Needed: ☐ Y ☐ N Date appointed: _____

Other Contact information

Name: _____ Relationship to Child: _____

Phone: _____ Other phone: _____

SECTION 3: SERVICE COORDINATION PROVIDER

BabyNet Intake Service Coordinator Name _____ Phone _____

BabyNet Ongoing Service Coordinator Name _____

Service Coordination Provider Agency _____ Phone _____

Other phone _____ Email address _____

Revised 9/11/06

Name (Last, First, MI): _____

DOB: _____

BabyTrac # _____

Medicaid # _____

CARES # _____

SECTION 4: IFSP TRACKING									
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IFSP Meeting Date:	Type of IFSP: <input type="checkbox"/> Initial <input type="checkbox"/> Annual
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Projected IFSP Team Meeting Dates:	
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6-Month Review	Annual Evaluation	Transition
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Quarterly Progress Summary Dates: Due 15 days prior to end of each quarter of service.

Q1	Q2	Q3	Q4
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Date IFSP mailed:	
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Family	Other IFSP Team Members	Primary Health Care Provider
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SECTION 5A: FAMILY'S VIEW OF CHILD'S CURRENT HEALTH

Refer to BabyNet Birth and Early Health History in completing this section

Primary Healthcare Provider:

Does your child have a primary health care provider? ☐ No ☐ Yes

If not, there should be a linkage to a provider (reflect as a service coordination goal).

Primary Health Care Provider:_____ **Phone:** _____

Address: _____ **Fax:** _____

General Health:

Is there anything about your child's current mental or physical health, including diagnosis(s) that the team should know about in order to better plan and provide services to you and your family?

[illegible]

Does your child have any allergies? ☐ No ☐ Yes If yes, please list:

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____

Does your child use any specialized medical equipment, i.e., oxygen, pulse ox, g-tube, ventilator

☐ No ☐ Yes If yes, please list:

Vision: Has your child's vision been tested? ☐ No ☐ Yes

If yes, Date: _____ Physician's Name: _____ (If the appointment was within the last 6 months, request the report and **DO NOT** complete Family Hearing and Vision Report)

Results of vision evaluation:

If no, proceed with the *Family Hearing and Vision Report* and indicate the results: ☐ Pass ☐ Monitor ☐ Refer

Referral to (Physician's name): _____ Date of appointment: _____

Other comments by family or IFSP Team:

Hearing: Has your child's hearing been tested? ☐ No ☐ Yes

If yes, Date: _____ Physician's Name: _____ (If the appointment was within the last 6 months, request the report and **DO NOT** complete Family Hearing and Vision Report)

Results of hearing evaluation:

If no, proceed with the *Family Hearing and Vision Report* and indicate the results: ☐ Pass ☐ Monitor ☐ Refer

Referral to (Physician's name): _____ Date of appointment: _____

Other comments by family or IFSP Team:

Nutrition: Are there any concerns about your child's eating, general nutrition, or growth? ☐ No ☐ Yes

☐ Special Formula (specify _____)

☐ Avoids certain textures

☐ Food allergies

☐ G-tube feedings (Bolus and/or continuous pump)

☐ Will only eat certain foods

☐ Special diet

☐ Other, please list (ex., transitioning from G-tube to oral feeding): _____

If yes to any conditions listed above please describe:

Other comments by family or IFSP Team:

Oral Health: Has your child's mouth and/or teeth been checked? ☐ No ☐ Yes

How long did your child use the following? ☐ Bottle _____ Mths/yrs

☐ Pacifier _____

Mths/yrs

Has your child been on any of the following medications for extended periods of time (3 months or more)?

☐ Seizure Medications

☐ Prescription Antibiotics

If yes to any conditions listed above please describe:

Name (Last, First, MI): _____

DOB: _____

BabyTrac # _____

Medicaid # _____

CARES # _____

SECTION 5B: HEALTH CARE PROVIDERS

Provider's Name _____ Specialty _____
Address _____ Phone _____

Provider's Name _____ Specialty _____
Address _____ Phone _____

Provider's Name _____ Specialty _____
Address _____ Phone _____

Provider's Name _____ Specialty _____
Address _____ Phone _____

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Provider's Name _____ Specialty _____
Address _____ Phone _____

Name (Last, First, MI): _____
DOB: _____
BabyTrac # _____
Medicaid # _____
CARES # _____

SECTION 6A: FAMILY VIEW OF CHILD'S PRESENT LEVEL OF FUNCTION**Social/Emotional:** Are your child's **social skills** or **emotional development** of concern to you? ☐ No ☐ Yes

- | | | |
|--|---|--|
| <input type="checkbox"/> Smiles | <input type="checkbox"/> Laughs | <input type="checkbox"/> Expresses comfort/discomfort |
| <input type="checkbox"/> Interest in Peers | <input type="checkbox"/> Responds to primary caregiver | <input type="checkbox"/> Anxious when separated from caregiver |
| <input type="checkbox"/> Shows different emotion | <input type="checkbox"/> Shows affection to familiar people | |

Other comments (if needed):**Communication:** Are your child's **communication skills** of concern to you? ☐ No ☐ Yes

- | | | |
|--|--|--|
| <input type="checkbox"/> Tracks movement or sounds with eyes | <input type="checkbox"/> Smiles | <input type="checkbox"/> Uses single words/phrases |
| <input type="checkbox"/> Grunts | <input type="checkbox"/> Points | <input type="checkbox"/> Talks in sentences |
| <input type="checkbox"/> Babbles, no words | <input type="checkbox"/> Indicates want/needs (looking, sounds, gestures, words) | |

Other comments (if needed):**Cognitive:** Are your child's **thinking or problem-solving skills** of concern to you? ☐ No ☐ Yes

- | | | |
|---|---|--|
| <input type="checkbox"/> Follows moving objects with eyes | <input type="checkbox"/> Looks at storybook, points to pictures often naming the item | <input type="checkbox"/> Attends to activities of interest for short periods |
| <input type="checkbox"/> Puts small objects in/out of container | <input type="checkbox"/> Imitates actions and words of adults | <input type="checkbox"/> Can match two similar objects |
| <input type="checkbox"/> Recognizes familiar people | | |

Other comments (if needed):**Self-help skills:** Are your child's **self-help skills** of concern to you? ☐ No ☐ Yes

- | | | |
|---|---|--|
| <input type="checkbox"/> Formula/Breast fed only | <input type="checkbox"/> Needs to be fed | <input type="checkbox"/> Needs to be dressed |
| <input type="checkbox"/> Suck-swallow-breath coordination | <input type="checkbox"/> Needs assistance with eating | <input type="checkbox"/> Cooperates with dressing |
| <input type="checkbox"/> Holds own bottle | <input type="checkbox"/> Finger feeds | <input type="checkbox"/> Removes socks, shoes |
| <input type="checkbox"/> Sucks/chews on crackers | <input type="checkbox"/> Feeds self with spoon | <input type="checkbox"/> Dresses independently |
| <input type="checkbox"/> Eats soft food only | <input type="checkbox"/> Feeds self with fork | <input type="checkbox"/> Toilet training in progress |
| <input type="checkbox"/> Eats solid foods | <input type="checkbox"/> Wears diapers | <input type="checkbox"/> Fully toilet trained |

Other comments (if needed):**Motor skills:** Is there anything about how your child **moves** that is a concern to you? ☐ No ☐ Yes

Name (Last, First, MI): _____
DOB: _____
BabyTrac # _____
Medicaid # _____
CARES # _____

SECTION 6B: ASSESSMENT OF CHILD'S PRESENT LEVEL OF FUNCTION

Date of IFSP	Child's Name
Child's <input type="checkbox"/> Chronological or <input type="checkbox"/> Adjusted Age at time of CBA: _____ years _____ months	
CBA Tool: <input type="checkbox"/> AEPS <input type="checkbox"/> HELP <input type="checkbox"/> The Oregon Project <input type="checkbox"/> The INSITE Development Checklist	Name and agency of CBA Provider <i>please print</i> :
Overall strengths of child, successful strategies used in the assessment, and factors that may have affected assessment process	
CBA Results for Social –Emotional Domain	
Social-emotional skills child currently demonstrates:	
Skills newly learned/emerging:	
Skills not yet learned:	
Percentage of Delay in this domain:	
Date CBA conducted	Signature of CBA Provider

Name (Last, First, MI): _____
DOB: _____
BabyTrac # _____
Medicaid # _____
CARES # _____

CBA Results for Cognitive Domain

Cognitive skills child currently demonstrates:

Skills newly learned/emerging:

Skills not yet learned:

Percentage of Delay in this domain:

CBA Results for Communication Domain

Communication skills child currently demonstrates:

Skills newly learned/emerging:

Skills not yet learned:

Percentage of Delay in this domain:

Date CBA conducted

Signature of CBA Provider

Name (Last, First, MI): _____
DOB: _____
BabyTrac # _____
Medicaid # _____
CARES # _____

CBA Results for Self-Help/Adaptive Domain	
Self-help/adaptive skills child currently demonstrates:	
Skills newly learned/emerging:	
Skills not yet learned:	
Percentage of Delay in this domain:	
CBA Results for Motor Domain	
Gross motor skills child currently demonstrates:	Fine motor skills child currently demonstrates:
Gross motor skills newly learned/emerging:	Fine motor skills newly learned/emerging:
Gross motor skills not yet learned:	Fine motor skills not yet learned:
Percentage of Delay in this domain:	Percentage of Delay in this domain:
Date CBA conducted	Signature of CBA Provider

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____

SECTION 6C: OTHER TEAM MEMBERS' VIEW OF CHILD'S PRESENT LEVEL OF FUNCTION*To be completed at Initial and Annual IFSP Team Meeting***Social-emotional skills:****Cognitive skills:****Communication skills:****Self-help skills:****Motor skills:**

Name (Last, First, MI): _____
DOB: _____
BabyTrac # _____
Medicaid # _____
CARES # _____

SECTION 7: FAMILY'S RESOURCES, PRIORITIES, AND CONCERNS (VOLUNTARY BY FAMILY)

- ☐ **Family declined family assessment of resources, priorities, and concerns** Parent's initials: _____
- ☐ **Date Family Assessment completed:** _____

I have questions about or want help for my child in the following areas (check all that apply):

1. ___ Moving around (crawling, scooting, rolling, walking)
2. ___ Ability to maintain positions for play
3. ___ Talking and listening
4. ___ Thinking, learning, playing with toys
5. ___ Feeding, eating, nutrition
6. ___ Having fun with other children; getting along
7. ___ Behaviors/appropriate interactions
8. ___ Expresses feelings
9. ___ Toileting; getting dressed; bedtime; other daily routines
10. ___ Helping my child calm down, quiet down
11. ___ Pain or discomfort
12. ___ Special health care needs

Other: _____

Family's remarks regarding concerns identified about their child (including any not listed):

I would like to share the following concerns and priorities for myself, other family members, or my child (check all that apply):

1. ___ Learning more about how to help my child grow and develop
2. ___ Finding or working with doctors or other specialists
3. ___ Learning how different services work or how they could work better for my family
4. ___ Planning for the future; what to expect
5. ___ Parenting skills
6. ___ People who can help me at home or care for my child so I/we can have a break; respite
7. ___ Child care
8. ___ Housing, clothing, jobs, food, or telephone
9. ___ Information on my child's special needs, and what it means
10. ___ Ideas for brothers, sisters, friends, extended family
11. ___ Money for extra costs of my child's special needs
12. ___ Linking with a parent network to meet other families or share information (☐ P2P ☐ PTIC ☐ CRS)

Other: _____

Family's remarks regarding identified priorities of the family (including any not listed):

Name (Last, First, MI): _____
DOB: _____
BabyTrac # _____
Medicaid # _____
CARES # _____

SECTION 8: ELIGIBILITY

☐ INITIAL eligibility determination* Date _____
 ☐ ANNUAL IFSP Date _____

STATUS

☐ Child is (continues to be) eligible
 ☐ Child is not (no longer) eligible for Part C services.

CRITERIA MET (if eligible)

INITIAL IFSP

- ☐ **Established Risk****
 Written documentation of a diagnosed physical or mental condition with known etiology and developmental consequences
- ☐ **Established risk (not otherwise specified)****
 BabyNet medical consultant confirmed that child's condition or diagnosis meets above criteria.
- ☐ **Developmental Delay**
 Curriculum-based assessment (CBA) reveals developmental delay(s) that meet criteria for initial BabyNet eligibility.

****List child's diagnoses**

ANNUAL IFSP

- ☐ **Established Risk****
 Condition previously documented continues.
- ☐ **Established risk (not otherwise specified)****
 Condition previously documented continues.
- ☐ **Developmental Delay**
 Curriculum-based assessment (CBA) reveals any developmental delay. (ANNUAL IFSP review only. Eligibility continues unless present level of performance in all domains has progressed to within normal limits (i.e., delays are less than 15% in all domains.)
 IDEA Part C (BabyNet) services continued in order to (*check one*):
 - ☐ Prevent regression (developmental losses)
 - ☐ Continue developmental gains
 - ☐ Help child reach developmental status of same-aged peers.

CURRICULUM-BASED ASSESSMENT (CBA) RESULTS

TOOL

- ☐ Assessment, Evaluation, and Programming System (AEPS)
 ☐ Hawaii Early Learning Profile (HELP)
 ☐ The INSITE Development Checklist
 ☐ The Oregon Project

Domain

Delay

Social-Emotional	_____ %
Cognitive	_____ %
Communication	_____ %
Self-Help/Adaptive	_____ %
Gross Motor	_____ %
Fine Motor	_____ %

INITIAL Eligibility Determination Team Members*

Participation

Name	Title/Agency	On-site	Phone/fax
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Eligibility Notes

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____

SECTION 9: OTHER SERVICES	
<p>An ‘other service’ is a service necessary or desired to assure optimal child and/or family functioning; but not part of IDEA Part C or covered by BabyNet.</p> <p>Other Services include, but are not limited to, housing, food stamps, WIC, TEFRA, clothing, respite, PCA, MR/RD Waiver service, including services in place at the time BabyNet eligibility established or added during implementation of the IFSP.</p>	

SECTION 9: OTHER SERVICES	
<p>An ‘other service’ is a service necessary or desired to assure optimal child and/or family functioning; but not part of IDEA Part C or covered by BabyNet.</p> <p>Other Services include, but are not limited to, housing, food stamps, WIC, TEFRA, clothing, respite, PCA, MR/RD Waiver service, including services in place at the time BabyNet eligibility established or added during implementation of the IFSP.</p>	

[illegible]

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____

SECTION 10A: CHILD/FAMILY CENTERED GOAL

A goal is a statement of change the family would like to see happen for themselves and/or their child.

Goal #:**Date of Goal:****Target Date:****GOAL:** What knowledge, skill or behavior would we like to learn or see learned by our child?**MEASURING PROGRESS:** What difference will this make for our child and/or family? How will we know when the goal has been met? List specific skills from the CBA that are components of this goal**NATURAL SUPPORTS:** Ideas, strategies, and people needed to achieve this goal within the child's everyday routines, activities, and places**ADAPTATIONS AND/OR MODIFICATIONS:** Special accommodations/adaptations/equipment that can help make this happen (Assistive Technology).**SERVICES TO CONSIDER:** What Part C and/or Other services are needed in order to achieve this goal in everyday routines, activities, and places?**WILL ALL SERVICES BE PROVIDED IN THE CHILD'S HOME & COMMUNITY ROUTINES & ACTIVITIES?**☐ **Yes**☐ **No:**☐ **Developmental/Medical Conditions**☐ **No Available Providers**☐ **Other:****JUSTIFICATION/EXPLANATION FOR PART C SERVICES OUTSIDE OF THE NATURAL ENVIRONMENT:**

What are the developmental, medical or other conditions that would require the service to be provided outside the family's home & community routines & activities?

Service**Include any interventions and/or efforts to provide services in everyday routines, activities, and places (RAP's) that were conducted and why these have been determined by the Team to be unsuccessful. The justification must include a plan for how services provided in any specialized setting will be generalized into the child's RAP's.**

Name (Last, First, MI): _____

DOB: _____

BabyTrac # _____

Medicaid # _____

CARES # _____

Goals may be reviewed, modified, and/or discontinued at any time but review period must not exceed 6 months. See IFSP Change Review, IFSP Six-Month Review and Annual IFSP Goal Attainment Scale information on the following page.

SECTION 10B: Periodic Review of Goal

Goal #: _____ **Date Reviewed:** _____ ☐ **Change Review** ☐ **6-month Review** ☐ **Annual Evaluation**

- | | |
|--|--|
| <input type="checkbox"/> 1-Situation changed, no longer needed
<input type="checkbox"/> 2-Situation changed, is still needed
<input type="checkbox"/> 3-Intervention started, is still needed
<input type="checkbox"/> 4-Goal partially attained or accomplished but not to team's satisfaction | <input type="checkbox"/> 5-Goal attained or accomplished but not to team's satisfaction
<input type="checkbox"/> 6- Goal mostly attained or accomplished to team's satisfaction
<input type="checkbox"/> 7- Goal attained or accomplished to the team's satisfaction |
|--|--|

Update to Natural Environments Justification Plan (developmental/medical conditions only):

Comments

Goal #: _____ **Date Reviewed:** _____ ☐ **Change Review** ☐ **6-month Review** ☐ **Annual Evaluation**

- | | |
|--|--|
| <input type="checkbox"/> 1-Situation changed, no longer needed
<input type="checkbox"/> 2-Situation changed, is still needed
<input type="checkbox"/> 3-Intervention started, is still needed
<input type="checkbox"/> 4-Goal partially attained or accomplished but not to team's satisfaction | <input type="checkbox"/> 5-Goal attained or accomplished but not to team's satisfaction
<input type="checkbox"/> 6- Goal mostly attained or accomplished to team's satisfaction
<input type="checkbox"/> 7- Goal attained or accomplished to the team's satisfaction |
|--|--|

Update to Natural Environments Justification Plan (developmental/medical conditions only):

Comments

Goal #: _____ **Date Reviewed:** _____ ☐ **Change Review** ☐ **6-month Review** ☐ **Annual Evaluation**

- | | |
|--|--|
| <input type="checkbox"/> 1-Situation changed, no longer needed
<input type="checkbox"/> 2-Situation changed, is still needed
<input type="checkbox"/> 3-Intervention started, is still needed
<input type="checkbox"/> 4-Goal partially attained or accomplished but not to team's satisfaction | <input type="checkbox"/> 5-Goal attained or accomplished but not to team's satisfaction
<input type="checkbox"/> 6- Goal mostly attained or accomplished to team's satisfaction
<input type="checkbox"/> 7- Goal attained or accomplished to the team's satisfaction |
|--|--|

Update to Natural Environments Justification Plan (developmental/medical conditions only):

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____

SECTION 10C: SIGNATURES FOR CHANGE REVIEW OF IFSP**Date Reviewed:**

I have:

☐ YES☐ NO

Received written prior notice of this meeting;

☐ YES☐ NO

Received a copy and explanation of my procedural safeguards; and

☐ YES☐ NO

Participated in the change review of this plan, and give informed consent for BabyNet to carry out the activity/activities on this IFSP.

Signature of Parent(s):**Date:****IFSP Team Members****Method Codes:** A = Attended, S = Speakerphone, E = Written Evaluation Only (not for ongoing service providers)

Signature/Name	Role	Agency (if applicable)	Method Code	Date
	BN Service Coordinator			

SECTION 10C: SIGNATURES FOR CHANGE REVIEW OF IFSP**Date Reviewed:**

I have:

☐ YES☐ NO

Received written prior notice of this meeting;

☐ YES☐ NO

Received a copy and explanation of my procedural safeguards; and

☐ YES☐ NO

Participated in the change review of this plan, and give informed consent for BabyNet to carry out the activity/activities on this IFSP.

Signature of Parent(s):**Date:****IFSP Team Members****Method Codes:** A = Attended, S = Speakerphone, E = Written Evaluation Only (not for ongoing service providers)

Signature/Name	Role	Agency (if applicable)	Method Code	Date
	BN Service Coordinator			

Name (Last, First, MI): _____

DOB: _____

BabyTrac # _____

Medicaid # _____

CARES # _____

10D: SIGNATURES FOR 6 MONTH REVIEW OF IFSP**Date Reviewed:**

I have:

☐ YES☐ NO

Received written prior notice of this meeting;

☐ YES☐ NO

Received a copy and explanation of my procedural safeguards; and

☐ YES☐ NO

Participated in the change review of this plan, and give informed consent for BabyNet to carry out the activity/activities on this IFSP.

Signature of Parent(s):**Date:****IFSP Team Members****Method Codes:** A = Attended, S = Speakerphone, E = Written Evaluation Only (not for ongoing service providers)

Signature/Name	Role	Agency (if applicable)	Method Code	Date
	BN Service Coordinator			

Name (Last, First, MI): _____

DOB: _____

BabyTrac # _____

Medicaid # _____

CARES # _____

[illegible]

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____

[illegible]

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____

SECTION 12: TRANSITION PLANNING			
Transition from Part C	Target Date	Completion Date	Responsible Individual(s)
Discuss and educate parents on future placements, what "Transition" from BabyNet System means and what we can do to plan for this transition. Explore preschool education services as well as community program options.	Age 2		
Discuss and educate parents about the differences between BN services and educationally related services under Part B of IDEA.	Age 2		
Discuss with family the need for current immunizations.	Age 2		
Determine need for new IFSP Goals to address transition-related knowledge, skills, and behaviors. Goal # _____ Goal # _____ Goal # _____ Goal # _____	IFSP closest to age 2		
As part of the local school district's child find efforts, your child's name, birth date, your name, address and phone number will be sent by the BabyNet System Managers no later than 2 years 3 months to the school district.	No later than Age 2yrs 3 months		
With Parental permission make a referral to LEA and send information/records about child to LEA to ensure continuity of services, including evaluation and assessment of information and IFSPs no later than 2 years 6 months to the school district using the <i>Transition Notification/Referral</i> form with Section 2 completed.	No later than Age 2 yrs 6 months		
Send specified information/records to community programs, upon written consent, to facilitate service delivery or transition from BabyNet Early Intervention.	No later than Age 2yrs 6 months		
Transition Conference to be held no less than 90 days prior to the child's third birthday and (no more than 9 months prior).	No later than Age 2yrs 9 months		
Complete activities specified in Transition Plan section of <i>Transition Conference Form</i> .	Age 3		
BN Service Coordinator attends IEP at parent request.	No Later than Age 3		

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____

SECTION 13: BABYNET SERVICES

<input type="checkbox"/> Add Service <input type="checkbox"/> Discontinue Service Date of IFSP Linked to Service: _____			
<input type="checkbox"/> Parent refuses/requests discontinuation of this service		Parent Initials: _____ Date: _____	
BN Service CODE and Name:		IFSP Goals to Address:	
Provider:		Planned Start Date:	Planned End Date:
Actual Start Date:	Actual End Date:	Method CODE :	Fund CODE(s) :
Setting CODE :	Visit Duration in Minutes:	Number of Visits: <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Every Other Month <input type="checkbox"/> Quarterly	
Travel Only: <input type="checkbox"/> No <input type="checkbox"/> Yes CODE _____		If required, is service setting justified? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If Child is Waiting for Service, Leave Start Date and Provider Blank and Enter Late Reason CODE :			
<input type="checkbox"/> Add Service <input type="checkbox"/> Discontinue Service Date of IFSP Linked to Service: _____			
<input type="checkbox"/> Parent refuses/requests discontinuation of this service		Parent Initials: _____ Date: _____	
BN Service CODE and Name:		IFSP Goals to Address:	
Provider:		Planned Start Date:	Planned End Date:
Actual Start Date:	Actual End Date:	Method CODE :	Fund CODE(s) :
Setting CODE :	Visit Duration in Minutes:	Number of Visits: <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Every Other Month <input type="checkbox"/> Quarterly	
Travel Only: <input type="checkbox"/> Yes <input type="checkbox"/> No		If required, is service setting justified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Child is Waiting for Service, Leave Start Date and Provider Blank and Enter Late Reason CODE :			
<input type="checkbox"/> Add Service <input type="checkbox"/> Discontinue Service Date of IFSP Linked to Service: _____			
<input type="checkbox"/> Parent refuses/requests discontinuation of this service		Parent Initials: _____ Date: _____	
BN Service CODE and Name:		IFSP Goals to Address:	
Provider:		Planned Start Date:	Planned End Date:
Actual Start Date:	Actual End Date:	Method CODE :	Fund CODE(s) :
Setting CODE :	Visit Duration in Minutes:	Number of Visits: <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Every Other Month <input type="checkbox"/> Quarterly	
Travel Only: <input type="checkbox"/> Yes <input type="checkbox"/> No		If required, is service setting justified? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____

SECTION 14: INITIAL AND ANNUAL IFSP CONSENT AND TEAM SIGNATURES**IFSP Meeting Notes:****Accepting BabyNet Part C Services Recommended by the IFSP Team**

- I have received a copy of my rights under Part C of IDEA (*Notice of Child and Family Rights in the BabyNet System*) and these have been explained to me along with this IFSP.
- My consent is voluntary and based on my understanding of the activities, which have been explained to me in my native language or mode of communication.
- I understand that my consent remains in effect until the next IFSP or IFSP Review and that I may revoke my consent in writing, at any time.
- I understand that I may decline a service or services without jeopardizing any other BabyNet service(s) my child or family receives.
- I understand that my IFSP will be shared among the service providers implementing this IFSP, others I may identify, and entities within the system per federal reporting requirements.

I have participated in the development of this plan, and give informed consent for BabyNet to carry out the activity/activities on this IFSP: ☐ Yes ☐ No

Signature of Parent(s):

Date:

IFSP Team Members

Method Codes: A = Attended, S = Speakerphone, E = Written Evaluation Only (not for ongoing service providers)

Signature/Name	Role	Agency (if applicable)	Method Code	Date
	BN Service Coordinator			

Name (Last, First, MI): _____
DOB: _____
BabyTrac # _____
Medicaid # _____
CARES # _____

[illegible]

Name (Last, First, MI): _____
 DOB: _____
 BabyTrac # _____
 Medicaid # _____
 CARES # _____